

## Book of the month

### Snake Oil and Other Preoccupations

In March 2001 Britain's most famous cancer sufferer finally succumbed to the metastatic squamous carcinoma of the tongue that had co-starred with him in the media for the preceding four years. It is astonishing that someone would want to share their entire personal cancer journey with us, from faltering diagnosis to near death, yet John Diamond did exactly that. He spoke about his condition to a growing audience through his weekly *Times* column, a documentary and a book, *C: Because Cowards get Cancer Too*<sup>1</sup>. Parts of his life were even dramatized as *A Lump in my Throat*, and performed on stage and TV. A final work, *Snake Oil and Other Preoccupations*<sup>2</sup>, was assembled posthumously by his brother-in-law Dominic Lawson. But this well-reasoned diatribe against alternative medicine stops abruptly in the middle of chapter 6. There was only enough new material for a quarter of a book, so Lawson padded out the remainder with other items from John's prodigious journalistic output (to call the author 'Mr Diamond' seems altogether too formal).

It is the selection of this additional material that bothers me. Among John's earlier pre-cancer work what, for example, is the point in including a piece lunging at herbalists for claiming that 'chemical' and 'natural' are somehow diametrically opposed when chapter 2 of *Snake Oil* has already expounded on the same theme? Among the post-cancer fare, why repeat verbatim nearly all of the columns already picked out for inclusion in his early book *C*? All the paraphernalia of this book, including a leaden introduction by Richard Dawkins (detailing randomized controlled trials when these are fully covered in chapter 5), indicate that it was rushed into print. Admittedly without Dominic Lawson's input the *bon mots* of *Snake Oil* could have been lost forever; yet I can't help feeling that a finer role for them would have been as an expansion and a lingering epilogue to a new edition of *C*.

At this point, readers who are not Diamond initiates may be asking why all this fuss about a dead journalist? How *bon* could one hack's *mots* really have been? Well, the short answer is, 'very'. For any doctor who has not read *C*, please go and do so: it will make you a better doctor. For anyone feeling smug because they have read it, go back and read it again, for its poignancy has now increased tenfold as a result of John's death.

One of the more uniform observations in oncology is that patients with a smoking-related malignancy such as

Diamond's tend to have very different mindsets from patients with breast cancer. The smokers, who are usually older and male, seldom ask, 'Why me?'. After the initial shock of diagnosis they quickly accept that they have a limited amount of time left and concentrate on the things they want to achieve before the end comes. In contrast, and perhaps not surprisingly, young breast cancer patients with metastatic disease much more commonly rage at the injustice of their fate. Marti Caine and Linda McCartney, and the journalist Ruth Picardie in five brutal, bolshy and heart-breaking articles<sup>3</sup>, attracted vast public sympathy before their deaths.

The smoking-related malignancies, which together are more common than breast cancer, get very little of the publicity and only a fraction of the funding that breast cancer receives for research, treatment and patient support. Perhaps the victims are perceived as less deserving, having had a hand in their own downfall. Perhaps, being older, they are more likely to be labelled as having had 'a good innings' and their personal loss thought of as something less. But John Diamond, with humour, candour and grainy panache, contrived to enter our hearts. And on the whole, as doctors, John loved us and trusted us in return. Though he was always ready to poke a little fun whenever fun-poking was due; for example, how he rubbished 'gradual disclosure'—what last week seemed like a jolly clever communication technique for passing on bad news, but this week seems more like an excuse for medical absent-mindedness. Though his writing was often moving—his postoperative narrative begins, 'I had fallen among nurses'—John always avoided mawkishness in his 'cancer testimony' by concentrating on the medical facts. Indeed he seems to have had a schoolboy-like fascination with facts, with reasoning things out and with passing on that understanding. Not to wrest back control of his life by one-upping his doctors, but because he was genuinely interested. What else would make a man enter the Marsden's pathology department to view the histology of his excised tumour? As a media figure confronting death he was plagued by well-wishers and salesmen sending details of their alternative 'cures' (the other C-word), and the factlessness of much alternative medicine inspired his writing to the end.

At present it is politically incorrect for doctors to criticize alternative medicine practitioners (though the favour is rarely returned), and everywhere they seem to have free rein to set up shop, mislead and extort money from the vulnerable. In *Snake Oil* John campaigns to redress this imbalance, to take the 'alternativists' apart with logic and to point out the idiocy of any philosophy that believes when standardized tests show ginseng-sucking not to work, it is the tests and not the treatment that should be thrown away. Sometimes a diagnosis of

cancer brings out the best in a person. The everyday tragedy of the condition is that, suddenly in the middle of things, you find that they are gone.

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- 2 Diamond J. C. *Because Cowards get Cancer Too*. London: Vermillion, 1998 [256 pp; ISBN 0-09-181665-3 (p/b); £6.99]
- 3 Picardie R. *Before I Say Goodbye*. Penguin, 1998 [116 pp; ISBN 0-140-27630-0 (p/b) £5.99]

### The Desktop Guide to Complementary and Alternative Medicine: an Evidence-based Approach

Editor: Edzard Ernst

444 pp + CD-rom Price £24.95 ISBN 0-7234-3207-4

London: Mosby, 2001

The past twenty years have seen a remarkable paradox in popular attitudes to medicine. While regulations for licensing drugs and appraising doctors have become increasingly stringent, more and more patients have turned to untested therapies supplied by unregulated practitioners. An increased demand for evidence-based medicine has been paralleled by a steady rise in therapies based on tradition and opinion. This divergence cannot be explained by two populations of patients: the evidence is that the same patients use both approaches. Patients considering any new treatment want to know if it works and if it is safe, but seem to have two different sets of rules. The divide is both linguistic and philosophical: terms such as 'natural', 'traditional' and 'holistic' are difficult to compare with confidence intervals and *P* values. So what happens if we judge both types of medicine by the same standards? Does complementary and alternative medicine (CAM) have a valid place alongside orthodox medicine?

The *Desktop Guide*, originating edited from the University of Exeter Department of Complementary Medicine, takes a serious look at the evidence for efficacy and safety of CAM. The opening section on investigative methods sets the tone of clarity, transparency and depth that characterize the book. Section 2, which summarizes diagnostic methods from bioresonance to the Vega-test, is informative and helpful. For each technique, published studies are systematically reviewed with verdicts ranging from 'the method is not valid' (iridology), through 'its value as a diagnostic tool seems limited' (Kirlian photography), to 'some but not all diagnostic methods are valid' (chiropractic). Section 3 takes us through therapies from acupuncture to yoga, and section 4 herbal and non-herbal medicine from aloe vera to yohimbe. Information

including constituents, rationale, pharmacological properties, clinical evidence, risks, and quality issues is clearly presented and well referenced. Phytoestrogen comes out rather well (reducing bone resorption in postmenopausal women) as does garlic, which at least in high dose reduces the frequency of tick bites. Red clover is safe but ineffective while shark cartilage is probably not even safe. A valuable series of tables summarizes herbs with adverse effects and interactions with antidiabetic and cardiac drugs, anti-coagulants and oral contraceptives.

Section 5 considers 38 conditions commonly treated with CAM (other conditions are indexed and discussed under individual therapies). The conclusions regarding atopic eczema—that conventional steroid treatments cannot be matched by CAM, and that therapies with the most promising evidence for efficacy are those with a psychological component—confirm my own impressions from the skin clinic. For migraine, biofeedback and possibly feverfew are effective and safer than conventional drug therapy. Similarly ginkgo is promising for tinnitus. Acupuncture and ginger are helpful for motion sickness and postoperative nausea.

For many therapies there is insufficient evidence to recommend them, but this deficiency must not be confused with lack of effect. What about the wisdom of centuries of sages? Surely years of experience reflected in 'expert opinion' must be valuable? The authors actually tested this hypothesis, by comparing CAM recommendations with evidence from their systematic reviews. Not only was there lack of agreement between seven general CAM textbooks, but in some cases a therapy was recommended when there was conclusive trial evidence that it was ineffective or even contraindicated.

The final section deals with general topics including legal, ethical and safety issues. Users of CAMs perceive them to be safer than conventional treatments, but must understand that 'natural' is not necessarily safe, unregulated preparations may be impure, and CAM providers sometimes delay or hinder access to potentially life-saving treatment if they cannot diagnose medical disorders. These concerns could all be addressed by better training and regulation of CAM

providers. The bottom line is that CAM is amenable to rigorous testing and some forms of CAM are supported by evidence and do have a role in modern healthcare.

The information in this book is balanced, authoritative and accessible. The enclosure of a CD-rom, with Medline links to all references as well as the whole text of the book, makes it astonishingly good value. The index might be improved in the next edition, but terms not listed (e.g. acne and psoriasis) can easily be found by searching the disc. This is a work which I will refer to every time a patient asks me about an alternative treatment.

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### **Benign Childhood Partial Seizures and Related Epileptic Syndromes**

C P Panayiotopoulos

406 pp Price £60 ISBN 0-86196-577-9 (h/b)

London: John Libbey, 2000

In the last quarter of the twentieth century, epileptology made considerable progress thanks to new neuroimaging techniques, better antiepileptic drugs, but probably above all more accurate definition and description of the epileptic disorders. 'Epilepsy' is not an entity: because epilepsies encompass many and various conditions, accurate diagnosis is essential for management and prognosis. This is the view of Dr Panayiotopoulos, who declares, 'Dramatic progress in the management of epilepsies can be expected if more time and emphasis are given on how to diagnose epilepsies rather than the current theme how to treat epilepsy'. Commissions of the International League against Epilepsy proposed categorizations, a classification of epilepsy syndromes in 1989, and an epidemiological classification in 1992. However, such proposals have a short half-life and must be updated and revised. Dr Panayiotopoulos' book is both an extensive review of established facts and also a critical view of current knowledge, based on his personal experience.

In chapter 1, under the heading The Diagnosis of Epilepsies the syndromic concept is convincingly championed. Chapter 2 demonstrates that the electroencephalogram (EEG) is not an obsolete tool but is indispensable for a correct diagnosis (magnetic resonance imaging is normal in some two-thirds of seizure patients). Chapter 3 offers a nice summary of these disorders, and also suggests that the term 'seizures' or 'seizure susceptibility' should be used instead of 'epilepsy'. Apart from the pathophysiological arguments, an objection to this proposal is that the best way to draw epilepsy out of the shadows and abolish its stigma is to accept the term.

Some syndromes are well defined and easy to diagnose if the necessary details are ascertained—as in most cases of

benign childhood epilepsy with centrotemporal spikes (chapter 4) and early-onset idiopathic childhood occipital epilepsy (chapter 8). They are astutely and thoroughly described here. The borders of benign childhood epilepsy with centrotemporal spikes and other conditions with a similar EEG pattern are detailed in chapter 5. Chapter 6 describes occipital seizures and chapter 7 shows that they occur in various epileptic disorders, symptomatic as well as idiopathic. The fact that, whereas rolandic seizures are mainly a manifestation of an idiopathic epilepsy, the same is not true in occipital seizures, is clearly shown. Correct diagnosis of late-onset benign childhood epilepsy is far more difficult (chapter 9). The pitfalls of a hasty interpretation of occipital epileptiform abnormalities are discussed at length in chapter 10.

After these updated descriptions, subsequent chapters place them in an historical frame. The obvious relationship between occipital seizures, occipital EEG foci and the role of cortex in visual functions leads to a discussion of seizures with specific modes of precipitation and mainly photosensitive epilepsies, illustrated with the author's personal studies. Differentiation of occipital epilepsies from migraines is justified because of the complex relation between migraine and epilepsy and the fact that, in 1978, cases of idiopathic occipital epilepsy were published as basilar migraine. Last, the author addresses the problem of the borders of the so-called benign partial seizure susceptibility syndrome, with other clinical phenotypes or other locations of EEG epileptiform abnormalities, and of what are called 'related epileptic syndromes' such as Landau-Kleffner syndrome, epilepsy with continuous spikes and waves during slow sleep and atypical benign partial epilepsy of childhood. Since the proposal of a classification of epilepsies and epileptic syndromes in 1989, epileptologists have divided themselves into splitters, admitting a host of specific syndromes, and lumpers, finding a continuum between epileptic events. Panayiotopoulos is both a splitter (read this book) and a lumper (read chapter 18). He is also a precursor, adding personal and astute views to an exhaustive review of the published work.

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### **Clinical Surgery**

Editors: Michael M Henry, Jeremy N Thompson

736 pp Price £34.95 ISBN 0-7020-1588-1 (h/b)

London: WB Saunders, 2001

*Clinical Surgery* has been modelled on the same publisher's *Clinical Medicine*, which has a strong following among students. As well as offering a beginner's guide to surgical

principles, it aims to serve graduates studying for the MRCS or AFRCS.

The first section, on general surgical principles, explains the structure of a surgical firm and how to set about training for a surgical career. Advice on obtaining patients' consent and on dealing with death and bereavement is well geared to the needs of students and trainees. A brief description of important conditions and procedures in the accident and emergency department is followed by some helpful aphorisms. I was surprised to find no advice here on avoidance of nasopharyngeal intubation in patients with suspected basal skull fracture; and there is no mention of the danger of using adrenaline in a digital ring block. A comprehensive chapter on surgical investigations is accompanied by detailed explanations of imaging principles, and the chapters on anaesthetic and analgesic principles, perioperative management and postoperative complications will be useful to the uninitiated. Unusually for a basic surgical textbook, *Clinical Surgery* also offers detailed coverage of critical care, multiorgan failure and the principles of oncology and transplantation. The contentious use of the 'no-touch' technique to avoid spillage of tumour cells during colectomy for cancer is advocated without qualification. A very good chapter on practical procedures is illustrated by clear diagrams.

The second section deals systematically with individual body regions. A sound algorithm for investigating neck swellings typifies the practical approach. Good chapters on otolaryngology, cardiothoracic and hepatic/pancreatic/biliary conditions follow. I did spot some weaknesses in the chapter on acute abdominal conditions. For example, it misses the opportunity to educate students on important non-surgical emergencies presenting as 'an acute abdomen' (e.g. acute myocardial infarction with ill-defined epigastric pain). Furthermore, the discourse on management of bleeding oesophageal varices due to portal hypertension should include at least a mention of the increasingly used transjugular intrahepatic portosystemic shunt. The classification of mechanical bowel obstruction into luminal, mural and extramural is logical although extramural (predominantly due to adhesions and hernias) accounts for over 95% of cases; it might be better for the student to learn about extramural causes first rather than putting gallstone ileus at the top of the list. The chapters on breast diseases and arterial and venous conditions are comprehensive and easy to understand. The 'icing on the cake', seldom offered in basic works of this sort, is section three with its chapters on the surgical subspecialties. Each chapter serves as a good introduction to that specialty up to the level required for the MRCS/AFRCS.

The book is attractively laid out in colour with many line drawings, clinical pictures, X-rays and scans. Clear, concise tables detailing important information are particularly

welcoming. I wholeheartedly recommend it to students looking for a surgical textbook.

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## Acne: Diagnosis and Management

William J Cunliffe, Harald P M Gollnick

160 pp Price £49.95 ISBN 1-85317-206-5 (h/b)

London: Martin Dunitz

Professors Cunliffe and Gollnick have produced a useful highly illustrated handbook for clinicians who manage patients with acne and related disorders. Although much of it deals with diagnosis and management (as the title indicates), almost a quarter is taken up with an in-depth account of the pathophysiology and microbiology of acne. This section gives up-to-date information on the routine and experimental techniques that can be used to investigate acne, perhaps directed largely at those doing skin research. On this theme it describes experimental evidence on the nature of the early inflammation in acne lesions and how disruption of the pilosebaceous follicle might result in an ongoing, cell-mediated, antigen-dependent immune response.

Since the target readership clearly includes dermatologists as well as general practitioners and other clinicians (hospital-based treatments such as roaccutane are included) the book would have benefited from more discussion of individual complications such as acne fulminans and inflammatory sinuses or cysts, but the common features of acne are handled very thoroughly. Much of the remainder of the book offers a detailed account of modern therapies for acne, including recent evidence for the efficacy and safety of the individual topical and systemic agents. This is particularly important in the areas of antibiotic-resistant *Propionibacterium acnes*, autoimmune and other side-effects of systemic tetracyclines and the safety of long-term systemic retinoids. These subjects are handled very clearly. Acne subtypes and the range of differential diagnoses are also well covered. This section will be especially useful to the non-dermatologist since it includes management options for many of these conditions as well as clinical descriptions and an atlas of clinical photographs.

Schering Health Care sponsored the book and some of their acne medications are mentioned by tradename rather than by generic name alone. However, perhaps for balance, one or two other treatments also include the tradename. There is certainly no bias towards the sponsoring company's treatments. In summary—a very well presented and well illustrated textbook.

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**A Practical Guide for Medical Teachers**

J A Dent, R M Harden

453 pp Price £34.95 ISBN 0-443-06275-0 (p/b)

London: Churchill Livingstone, 2001

In medicine our professional self-confidence has lately been eroded by the unrealistic expectations of a consumer society and a shamefully large number of medical disasters. Naturally enough, we wonder if our highly exposed shortcomings have their root in the way we educate doctors. So we traitorously acquiesce in the general derision of the traditional curriculum. You know the sort of thing: the preclinical course is time spent in the company of a cadaver; ward attachments are serial episodes of ritual humiliation; the preregistration year is endurance training in sleep deprivation. And we sit on committees to discuss how to do better.

Various prescriptions have been written. Very senior doctors are inclined to suggest increasing doses of Mozart and Dostoevsky, though one always suspects that this apparently radical idea might not differ much from the very senior doctors' own plans for a fulfilling retirement. In any case, it's not clear that deep appreciation of artistic achievement correlates very closely with the capacity for caring for others. If your mother were sick, would you choose Martin Amis to look after her? The General Medical Council has gone into the matter and issued a report recommending that the burden of factual information should be reduced and time made available for ethics, communication skills and the social sciences. And there's a strong belief that it's not just content but the manner in which it's taught that counts. A new breed of medical educators is replacing lectures and bedside teaching with goal-directed learning, clinical skills centres, tutor reports,

project work and assessment instruments. Here's a book about how to keep up.

Its strength is the comprehensive description it gives of the paraphernalia of modern undergraduate teaching methods. There are chapters on integrated learning, independent learning, problem-based learning and distance learning. Others deal with objective structured clinical examinations, constructed response questions and formative assessment. There's advice about how to produce a study guide, staff development and the monitoring of academic standards. But don't expect to be flattered. The authors rate the experience and teaching ability of the clinicians at whom the book is aimed at an insultingly low level. They think it necessary to remind us not to fiddle with the loose change in our pockets when lecturing, to make sure that we can be heard at the back of the auditorium and that an occasional appropriate joke may recapture students' attention. The only humour in this book, I must warn you, is unintentional.

They're a confident bunch, these medical educators. 'All involved in teaching in the healthcare disciplines will benefit from this view of current developments in medical education' is the self-assessment in the preface. Just how much benefit you will derive from reading this book will depend on your tolerance of bullet points and plonking generalizations. If you don't mind reading that 'medicine is constantly changing and doctors are expected to keep abreast of new developments' or that 'feedback informs students about how they are performing in relation to the learning situation', you may well find it useful. After thirty-nine chapters of this sort of stuff, I found myself longing for the wit and pace of *Gray's Anatomy*.

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**Other books received**

'As the old man walked the beach at dawn, he noticed a young man ahead of him picking up starfish and slinging them into the sea. Finally catching up with the youth, he asked him why he was doing this. The answer was that the stranded starfish would die if left until the morning sun. "But the beach goes on for miles and there are millions of starfish" countered the other. "How can your effort make any difference?" The young man

looked at the starfish in his hand then threw it to safety in the waves. "It makes a difference to this one", he said.'

The above story is the late David Baum's contribution to *Twice Daily after Meals*<sup>1</sup>—a work compiled by Dr SK Goolamali, with royalties destined for the Royal Medical Benevolent Fund. More than sixty celebrated individuals obligingly provided a piece of wit or wisdom or both, along with a biography and a photograph. (Sometimes the biographies dwarf the W&W.) If David Baum represents wisdom, wit is perhaps best served by Tony Benn with his story of a boat race between crews from Japan and the

National Health Service (the NHS boat, which lost, had eight people steering and one rowing...). Support the RMBF and find this anecdote on p. 39.

*A Flickering Lamp*<sup>2</sup> is David Hay's history of the Sydenham Medical Club, a dining club for London consultants that began in the late 1700s as the Monday Medical Club, with numbers limited to six physicians, six surgeons and six apothecaries. Although the membership has included some great names of medicine—Bright, Liston, Rosenheim—it seems that the criterion for entry was clubbability rather than intellectual stature or reforming zeal (also, so far, no women). What did the members talk about at their dinners? Alas the records tell us very little, though a flavour emerges from lists of wagers, seemingly a favourite activity in the 1800s. For example, in 1854 Henry Lee bets Edward Tegart 3 to 1 'that Miss Nightingale is not married by the next meeting'. This probably means that Tegart had to buy the wine. Mr Hay writes pleasingly, but the book is based largely on material from external sources and lacks meat for the serious historian. It will doubtless appeal to the friends and families of present members and to the descendants of past members whose biographies appear. The Club and its survival might also be of interest to anthropologists.

*Early Medical Schools in Nigeria*, by Adelola Adeloje<sup>3</sup>, begins with the story of Africanus Beale Horton, who in 1858 was one of the first Africans to qualify in medicine from a British school. Returning to West Africa as an Army surgeon, Horton begged the British government to establish a school in Sierra Leone for the training of Africans as medical doctors. The request was refused and until the 1930s medical education in British West Africa was achieved largely through the efforts of Christian mis-

sionaries. The first Nigerian medical school, at Yaba, began in 1930 and offered a four-year course. Staffing and facilities were poor and the licentiates were perceived to be (and paid as if) inferior to those trained in the UK. This generated much rage: in Adeloje's judgment, 'Perhaps the most outstanding contribution of the Yaba Medical School... was the development of political consciousness'. Yaba closed in 1948 when a new medical school opened in Ibadan, affiliated to London University. Another school opened at Kano in 1955 but soon closed after producing 18 graduates. The book is mainly about Ibadan, where Adeloje was Professor of Neurological Surgery—its ups and down, the great characters on the staff (many of British extraction), the impressive graduates. Since Independence in 1960, Nigeria has set up twelve more medical schools, and he is worried about uneven standards and student wastage. Part of the answer, he thinks, is a national qualifying professional examination akin to the old British Conjoint, with an emphasis on clinical competence rather than textbook knowledge.

**Robin Fox**

Editor *JRSM*

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- 2 Hay D. *A Flickering Lamp: a History of the Sydenham Medical Club (1775–2000)*. Available from EDA Hay, Stoke Hill Farm, Andover, Hampshire SP11 0LS, UK [252 pp.; ISBN 1-85065-491-3; £20 (including post and packing)]
- 3 Adeloje A. *Early Medical Schools in Nigeria*. Ibadan: Heinemann Educational Books (Nigeria) [ISBN 978-129-818-9]